OFFICE OF THE INSPECTOR GENERAL FOR MENTAL HEALTH, MENTAL RETARDATION AND SUBSTANCE ABUSE SERVICES

Primary Inspection
Piedmont Geriatric Hospital

James W. Stewart, III
Inspector General

Report #112-05

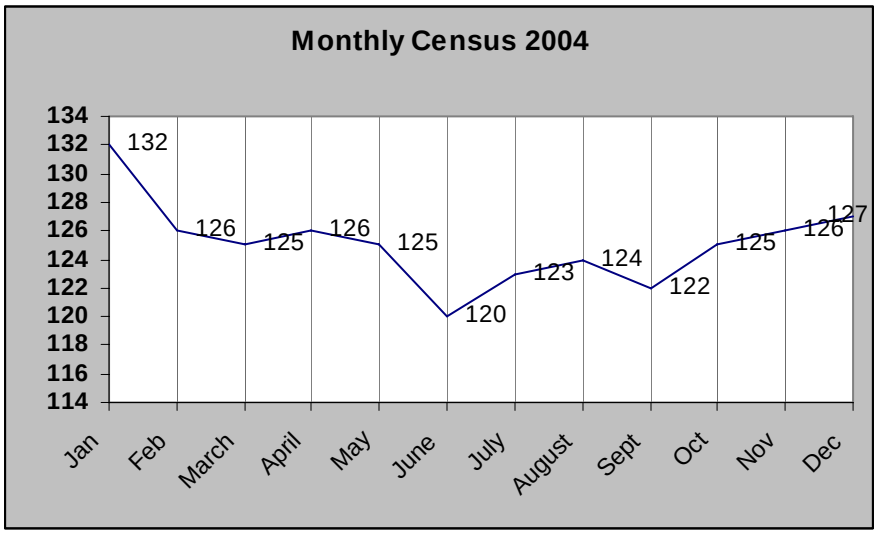
PIEDMONT GERIATRIC HOSPITAL
BURKEVILLE, VIRGINIA
February 16-17, 2005
OIG Report #112-05

INTRODUCTION: The Office of the Inspector General (OIG) conducted a primary inspection at Piedmont Geriatric Hospital (PGH) in Burkeville, Virginia during February 16 -17, 2005. The inspection focused on a review of the facility through the application of 19 quality statements. These statements are grouped into 6 domains that include facility management, access to services, service provision, discharge, quality of the environment, and quality and accountability. The quality statements were formulated through interviews completed by the OIG with a number of stakeholder groups. These groups included the mental health facility directors, consumers, Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS) Central Office administrative staff, DMHMRSAS Office of Mental Health Services staff and directors of mental health services for community services boards (CSB). The quality statements and the information obtained by the OIG through observations, interviews and a review of documents are described in this report. The report is divided into sections that focus on each of the domains previously noted.

SOURCES OF INFORMATION: Interviews were conducted with 27 members of the staff including administrative, clinical and direct care staff. Interviews were also completed with 4 consumers. Documentation reviewed included, but was not limited to 4 consumer records, selected policies and procedures, staff training curricula, facility quality management plan, and risk management reviews. A tour of the facility was conducted. Graphs in this report were created from data provided by the facility.

BACKGROUND: PGH is the only DMHMRSAS operated facility dedicated to the care and treatment of adults over the age of 65. The facility has an operating capacity of 135 beds. The census of the facility at the time of the inspection was 122. PGH is the primary facility for twelve CSBs. These include: Chesterfield, Crossroads, Danville-Pittsylvania, Goochland-Powhatan, Hanover County, Henrico County, PD19, Rappahannock, Rappahanock-Rapidan, Region X, Richmond and Southside. The budget for this facility in FY 2004 was $17,935,719 with the reported expenses for the same period being $17,935,719. The facility's budget for FY 2005 is $18,402,229. This represents an increase in funding from the actual expenses of the previous fiscal year of $466,510. The facility reported that the cost per bed day at the time of the inspection was $416.79 as of 12/31/04.

The following graph provides information regarding the facility's census during calendar year 2004.



MENTAL HEALTH FACILITY QUALITY STATEMENTS

Facility Management

1. The facility has a mission statement and identified organizational values that are understood by staff.

Administrative, clinical and direct care staff had a working knowledge of the facility's mission and values. The mission statement and organizational values are reviewed during new staff orientation. They are included in the employee handbook. Copies of the mission statement are posted on each unit.

The mission statement is:

> *It is the mission of Piedmont Geriatric Hospital to provide treatment for the mentally ill elderly that will prepare them to return to the community.*

The general principle of organizational ethics states:

> *All patients, employees, and visitors deserve to be treated with dignity, respect and courtesy.*

Additional organizational values include:

- *The provision of quality services*
- *Recognizing the contributions of each staff member*
- *On-going education and training to assure that the facility remains a leader in geriatric healthcare*

It was reported that the leadership team reviewed the mission and values last year.

2. The facility has a strategic plan

The facility submits its written strategic plan to DMHMRSAS every two years for review. It was last submitted in 2003. Administrative staff reported that the facility's strategic plan emphasizes ways in which the facility can work in partnership with the community to serve the geropsychiatric population. Among the strategies identified in the plan are the following:

- To increase the facility's involvement with universities in providing internships and fellowships to educate a variety of disciplines in effective methods for working with this population
- To support the work of the geropsychiatric special populations taskforce by serving as a pilot project site
- To utilize the professional staff and their knowledge to support community providers through consultations and other outreach services particularly prior to admissions

3. The mission and strategic plan have been reviewed and are linked to the recently adopted DMHMRSAS Vision Statement.

Administrative staff reported that the facility's leadership team has discussed the mission of the facility in conjunction with the DMHMRSAS Vision Statement but that no modifications in the facility's mission have been made to date.

4. There are systems in place to monitor the effectiveness and efficiency of the facility.

Interviews revealed that the facility has a number of systems in place to monitor its effectiveness. Every year the leadership team establishes priorities for performance improvement based upon a review of data monitored by the facility. Outcome measures are then established. The facility's leadership team and relevant disciplines review the data quarterly. The facility monitors data in such areas as the number of falls and consumers' injuries, the number of consumers that require the use of 1:1 staffing, medication errors, and the length of stay of the consumers. Staff stated that the data in each of these areas provides the facility with useful information for determining the effectiveness of services and interventions.

Among the performance improvement initiatives targeted for implementation during FY2005 are:

- An evaluation of the changes to the Master Treatment Plan
- An evaluation of the combined program changes to Ground Floor and 2 West
- Access to after-hours pharmacy
- Improved Medication orders and monitoring of unapproved abbreviations on orders

The facility monitors data related to staff effectiveness such as the number of family complaints, the number of patient infections, patient injuries, and medication errors to determine if there is a relationship between the frequency of occurrence and staffing patterns.

Administrative staff stated that the facility monitors its efficiency by operating within the approved budget and monitoring the admissions unit, patient length of stay and by tracking the 30-day readmission rate. It was reported that as a result of closing one unit within the past year, the facility has been serving more patients with fewer beds. Reportedly this has been accomplished through effective utilization review and active discharge planning.

5. There are systems in place to assure that there is a sufficient number of qualified staff.

Data provided by the facility indicated that PGH has 345 approved full-time employee positions, 298 of which were filled at the time of the inspection. Of these full-time positions, there were 86 Direct Service Associate II positions and 79 licensed nursing positions, including supervisory staff.

PGH staffing also includes the following numbers of clinical staff:

- 7 FT physicians, including the Medical Director. This count includes 4 psychiatrists and 3 medical doctors.
- 4 FT psychologists, including the director. Three of these individuals have a PhD and one a Master's degree.
- 8 FT social workers, including the director. This includes 1 LCSW, 5 MSWs and 2 BSWs.
- 11 FT activity therapists. This includes 2 occupational therapists, 3 music therapists, and 6 recreational therapists.
- The facility has a contract for pharmacy services. The contract allows for 2 FT pharmacists and 3 pharmacy technicians.

The direct care positions, including human service care workers and nurses, have traditionally been the positions that are the hardest to fill. The facility reported that the average salary for the recently hired registered nurse positions was $45,943 and for the direct care staff, $18,026.

Administrative staff reported that the daily staffing schedule is established to assure no less than 5 hours of care per patient per day. Services are monitored on each shift to assure an adequate number of direct care and supervisory staff.. Since PGH has had difficulty securing coverage for the second and third shifts, it is expected that all nursing staff rotate across all 3 shifts. For staff who are assigned permanently to the second and third shifts, a shift differential is paid. The rotating schedule continues to be a source of frustration for some of the nursing staff who were interviewed.

Unit staffing patterns for registered nurses (RN), psychiatric practical nurses (PPN) and psychiatric nursing assistants (PNA) were as follows:

1st Shift (2/16/05)

- On the Ground Floor or Medical unit, there were 4 RNs, 2 PPNs, and 5 PNAs for a census of 33 consumers. There were 2 consumers who required 1:1 observation.

- On 1 West, there were 4 RNs, 2 PPNs and 7 PNAs for a census of 27 consumers.

- On 2 West, there were 2 RNs, 2 PPNs, and 5 PNAs for a census of 28 consumers. Because of flexible scheduling for staff, the number of PNAs was reduced to 2 the hour and a half prior to the shift change.

- On 3 West, there were 2 RNs, 2 PPNs, and 8 PNAs for 32 consumers. One consumer required 1:1 staffing. In addition, the unit coordinator and program coordinator were available for coverage as needed.

1st Shift (2/17/05)

- On the Ground Floor or Medical unit, there were 2 RNs, 2 PPNs and 6 PNAs for 31 consumers.

- On 1 West, there were 3 RNs, 1 PPN, and 6 PNAs for a census of 28 consumers. One consumer required 1:1 staffing for transportation to an outside medical appointment.

- On 2 West, there were 3 RNs, 4 PPNs and 6 PNAs for a census of 28 consumers. Three of the PNAs were scheduled to be off the unit for the last 1.5 hours of the shift.

- On 3 West, there were 2 RNs, 3 PPNs and 7 PNAs for a census of 32 consumers. One consumer required 1:1 staffing.

Administrative staff reported that the facility takes steps to assure that staff are qualified to perform their defined duties. The direct service associate position has a minimum requirement of a high school education but preference is given to those individuals who are certified psychiatric nursing assistants. The facility provides an intensive six-week orientation and training program for direct care staff. This is to ensure that all newly hired direct care workers have the same basic understanding of their job duties and the expectations for working with the unique consumer population. Staff are expected to pass either written tests or be able to demonstrate competence in key functional areas to their immediate supervisor prior to assuming sole responsibility for consumers. This process allows for any deficiencies in practice to be corrected. In addition, PGH requires that staff be recertified annually in selected areas of training such as human rights.

6. There are mechanisms for direct care staff and clinical staff to participate in decision-making and planning activities.

The OIG was informed that each unit has a planning team that meets regularly to discuss the needs of the consumers so that the development of unit-wide activities is consistent with the consumers' overall cognitive and physical functioning. It was through a similar process that the facility developed its original SMILE program. This unit planning team is different from the treatment team, which focuses on the training and treatment needs of the individual. The treatment team is also a forum for staff to address concerns and or provide suggestions for care.

Staff is encouraged to participate on the various committees and performance improvement teams. In addition, each discipline holds departmental meetings at which staff can make suggestions and identify concerns.

Nine of the 11 direct care staff interviewed reported having opportunities to participate in the overall facility planning process. The following were mentioned as methods available for providing feedback:

- Communication with supervisor
- Hospital-wide meetings that occur on all shifts
- The facility suggestion box
- Unit/staff meetings

7. Facility leadership has a plan for creating an environment of care that values employees and assures that treatment of consumers is consistent with organizational values.

Even though the facility did not have specific written plans regarding methods for creating an environment of care that values employees and assures that treatment of consumers is consistent with organizational values, those interviewed were able to provide several relevant strategies.

Members of the leadership team reported that it was the employee's immediate supervisor who serves as the most important link in expressing appreciation for the work being completed on an on-going basis. Supervisors are trained and encouraged to actively praise persons they supervise when it is warranted. Small rewards, such as donuts or pizza, are provided as a way of showing employees that they are valued.

The facility holds annual events designed to highlight and recognize the employees. These include the staff picnic in the spring, an all facility ice cream social in the summer, Nurses Appreciation events during National Nurses Week and the facility Christmas Party.

Nine of the 11 direct care staff interviewed stated they feel valued by both the facility leadership and their supervisor. All spoke of the special rewards provided by their supervisor on an on-going basis and the special events mentioned above.

Administrative staff provided information regarding ways the facility assures that the treatment of consumers is consistent with organizational values. The primary method is the on-going training of staff in key policies relevant to human rights and reporting abuse and neglect. In addition, staff is expected to enable each consumer to participate in the treatment process to the fullest extent possible.

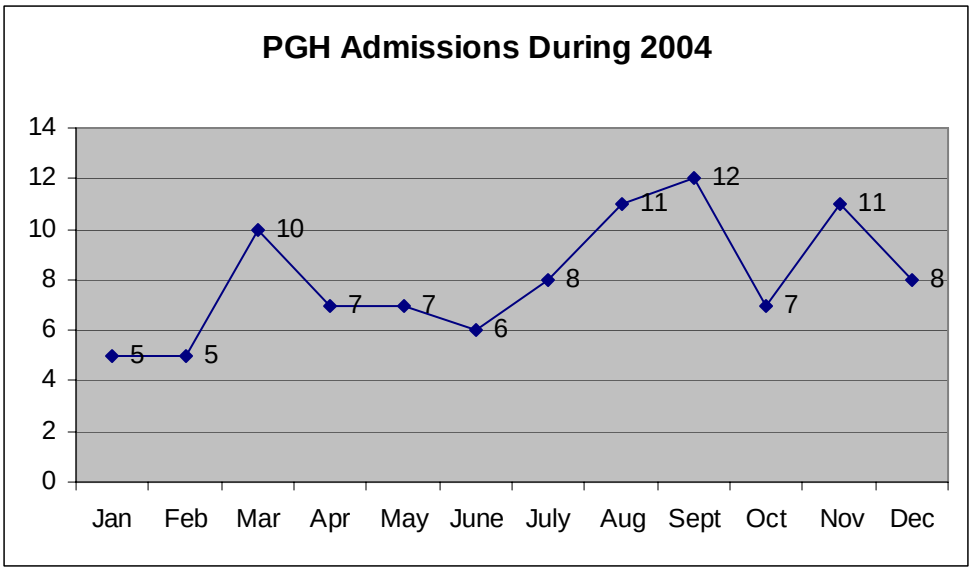
Access

1. There are systems in place to assure that those admitted to the facility are appropriate.

Interviews, a review of the facility admission policy and a review of clinical records demonstrated that the facility has a system for assuring appropriate admissions. PGH admissions occur through the twelve CSBs within the facility's catchment area. As with all DMHMRSAS operated facilities, the prospective consumer must be assessed by a prescreener from the appropriate CSB prior to being admitted. The prescreener determines whether the consumer meets the criteria for admission to an acute care setting, which is determined by the presence of imminent risk to harm self or others or substantially unable to care for themselves due to a mental illness. In addition, the prescreener assures that there are no less restrictive alternatives to hospitalization that will address the individual's needs.

Nursing administration reported that a thorough medical screening is a very important component of the admission process for this facility because PGH is not able to adequately treat acute medical conditions. A thorough medical examination, including history, allows for an assessment of the presenting symptoms to determine whether the etiology is associated with a physical condition or a serious mental illness. Of the 122 consumers at the facility on the first day of the inspection, 67 or 54% had a primary diagnosis of dementia.

Data provided by the facility revealed that there were 172 requests for admission and 97 admissions during calendar year 2004. Of the total admissions, 48 were male and 49 were female. The following chart tracks admissions on a monthly basis during 2004.



Of the total requests for admission, 58 were diverted to other facilities for care and 17 were denied. The primary reasons that admissions to the facility were denied included:

- The applicant was determined to be medically unstable and not suitable for admission
- The applicant was younger than 65.

2. The facility works collaboratively with CSB's to assure access to appropriate services when admissions to the facility are inappropriate or not possible due to census.

Staff stated that PGH works cooperatively with the CSBs to secure appropriate services when admission to the facility is determined to be inappropriate. If the consumer is determined to be appropriate for admission but the facility is full, PGH admission staff seek admission to another state-operated facility until a transfer back to PGH can be arranged.

Service Provision

1. There are systems in place to assure that the patient receives those services that are linked to his/her identified treatment needs and barriers to discharge.

Each consumer admitted to the PGH undergoes a series of assessments by a number of disciplines. A nursing screening of both medical and psychiatric risk factors occurs within the first half-hour of the admission process. A complete physical examination and psychiatric evaluation are completed within the first 24-hours of admission. The majority of assessments, which form the basis for the individualized treatment plan, are to be completed prior to the formal treatment planning session, which occurs within seven days of admission. Interviews with clinical staff revealed that treatment objectives are prioritized with a focus on those objectives that deal with "barriers" to the person re-

entering the community. Through record reviews it was determined that the treatment teams identify the barriers to discharge for each resident and develop interventions to address these barriers during hospitalization. Treatment objectives are formulated with the involvement of the consumer, family and/or legally authorized representative (LAR) and community liaison.

The OIG team observed consumer activities during the inspection. Formalized active treatment programming is offered to consumers based on their cognitive abilities and level of functioning. Even though a variety of activities were planned, a number of the scheduled programs were cancelled due to a variety of reasons. In those areas where programming did take place, the majority of consumers were not actively engaged.

The Ground floor is the skills preservation unit. Consumers on this unit typically have late stage dementia with moderate to severe cognitive impairment, are ambulatory and can perform some activities of daily living with cueing and assistance. The day treatment program activities are provided on the unit or in the adjacent wing in order to decrease confusion and agitation. Interviews revealed that the day treatment program is designed to stimulate interaction and to keep the patients connected by engaging them in meaningful activities. On the day of the visit, a number of activities were adjusted because a number of the consumers on this unit were experiencing flu-like symptoms. OIG staff was informed that normally 4 of the 33 consumers attend active treatment programming on 2 East, while the remaining consumers participate in activities on the unit such as music and recreational therapy. Seven consumers were observed watching television in the dayroom during the time period when normal programming would have occurred. The remaining consumers were in their beds.

1 West is the skills mastery unit. Consumers on this unit have a chronic mental illness and/or mild to moderate dementia with behavioral problems. Programming for this unit is based on the role recovery rehabilitation model. This model seeks to provide adapted rehabilitation activities for persons with multiple levels of cognitive, physical and mental impairments. Upon entering the unit, OIG staff was informed that the consumers on 1 West were involved in a morning meeting. OIG staff observed approximately 20 consumers sitting in the programming area watching television, while they were also receiving medications. OIG staff did not notice any interaction that would indicate a meeting was occurring.

OIG staff was informed that regular unit programming had been cancelled due to the strong smell of tar in the immediate area. The smell was due to roof repairs. It was explained that alternate activities such as watching movies and playing games were being offered in the cafeteria throughout the day for those consumers wanting to participate.

2 West is the behavioral and medical unit. Consumers on this unit are typically severely cognitively impaired, non-ambulatory, increasingly frail and have multiple health problems. Regular programming was operating as scheduled. The program being offered was entitled Sensory Stimulation. OIG staff observed 8 consumers in the activity room with a therapist. The therapist worked with each consumer individually while music was

playing in the background. While the therapist was involved with one individual, the other consumers sat quietly. During a tour of the unit, OIG staff noted there were an additional 8 consumers in the hallway sleeping, while others were in their beds.

3 West is the behavioral unit. This unit contains the most behaviorally challenged and aggressive consumers. The behavior management day treatment program is located on 3 East. OIG staff observed an Arts and Crafts painting group. The 10 consumers were not actively participating in the painting assignment so the staff offered music activities that were more successful. Consumers that were scheduled to go to the Senior Recreation Center received services on the unit the afternoon of the visit because the Center was closed due to a staff shortage. The majority of unit staff attended the funeral service held for a recently deceased staff member. A group of 9 consumers was engaged in an exercise group. An additional activity observed by the OIG involved 14 consumers who were watching television. Four staff members were present. There was little interaction between staff and consumers. Six of the 14 consumers in the group were sleeping. During a tour of the unit, 5 other consumers were observed in other rooms sleeping.

2. There are processes in place that support evidence-based practices.

PGH has a number of processes in place that support evidence based practices. The medical staff monitors compliance with medication adherence and effectiveness. Documentation regarding the provision of informed consent is maintained and was evident in the records reviewed. All four of the consumers interviewed reported receiving some information regarding the benefits associated with their medication but none of them indicated they had been fully informed of the risks and side effects.

The medical executive committee routinely reviews and discusses the current literature regarding prescription practice guidelines for geriatric patients. In addition, medical staff participates in grand rounds and other training activities. The facility monitors medication usage, PRN practices and the use of polypharmacy.

The OIG was informed that the facility is participating in a research project through the University of Maryland to determine whether or not behavioral approaches determined to be effective with persons with developmental disabilities can be used with persons with severe dementia to effect behavioral changes. To date, the project has trained the designated staff in behavioral principles and in conducting behavioral observations.

The facility monitors practice related to the prevention of falls, pressure ulcers, and pain management.

3. The facility assures that service provision is grounded in the principles of recovery, self-determination and empowerment.

The facility has been reviewing the current literature to determine the best models for incorporating recovery principles in serving the geriatric population. According to the administrative and clinical staff interviewed, one of their first considerations has been creating an environment in which staff acknowledges the importance of treating each person as an individual. Consumers and their LARs are encouraged to develop advanced directives, wills and to discuss with staff their desires regarding the consumer's quality of life. Over the last year, the facility has been working closely with the local hospice program to assure that consumers' desires regarding being able to die with dignity are followed.

None of the 11 direct care staff interviewed were able to identify ways in which the principles of recovery, empowerment and self-determination were used within the facility.

4. There are systems in place to measure the perceptions of consumers, families, direct care staff, clinical staff and administrative staff regarding the quality of the provision of care and services.

Interviews demonstrated that the facility has systems in place to measure the perceptions of the consumers, families, LARs and staff regarding the quality of the provision of care and services.

Each unit has a representative who attends the patient council meetings to discuss any issues or concerns that have been identified. Information from these meetings is communicated to individual unit management for review and resolution. Concerns that have facility-wide implications are referred to the leadership team for review. To address some issues, performance improvement teams are established.

Satisfaction surveys are conducted with families and LARs annually during hospitalization and at discharge. Survey results report a 95% consumer satisfaction rating with measures relevant to service provision and the environment of care. The informal complaint process is another procedure for addressing concerns.

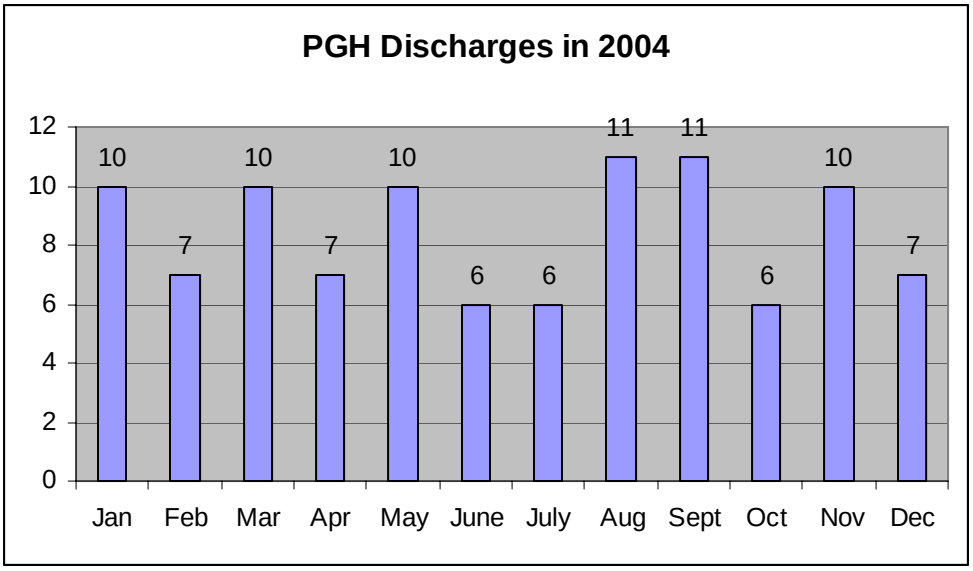
Staff perceptions are measured in supervisory meetings, team meetings, and formal satisfaction surveys.

Discharge

1. There are systems in place for effective utilization review and management.

Utilization review (UR) and utilization management occur at two levels. The facility Utilization Review Committee focuses on the total facility census and treatment teams focus on consumers in their units. The UR coordinator reviews each case to assure that the admission was appropriate. Chart reviews are conducted to assure that the documentation adequately reflects the goals of treatments, discharge plans and the on-going justifications for continued hospitalization. Clinical staff, particularly nursing and social work, evaluate the consumers daily for discharge readiness. The UR committee conducts a case-by-case review of the consumer's length of stay with a focus on facilitating discharge as soon as it is clinically possible. Cases where hospitalization has extended beyond the timeframe initially established by the treatment team are regularly reviewed.

The following chart displays discharges by month during 2004. There were 101 discharges during the year.



2. There are systems in place to assure that effective communication occurs between the patient, facility and community liaisons regarding discharge readiness in order to assure a smooth transition of the patient into the community and to prevent re-hospitalization.

Administrative staff reported that contact with the appropriate CSB community liaison begins at the time of admission. The community representative is invited to participate in all treatment and discharge planning sessions. Telephone conferencing is used when distances prohibit attendance. Social workers serve as the primary point of contact between the facility, the consumers, the LAR and the community. Interviews revealed

that social workers from the facility maintain weekly contact with community liaisons to discuss cases and to review discharge readiness and plans. Information from these meetings is communicated to all parties involved including the consumer and potential treatment providers. Contact increases as the time of discharge approaches. It is the primary responsibility of the facility in partnership with the consumer and/or LAR to determine the needs of the consumer upon discharge. This information is communicated to the community liaison who is responsible for facilitating the arrangements for service provision, housing and other identified service needs. The liaison also helps to make appointments with community providers. Interviews revealed that effective discharge planning and well-established community linkages are the best mechanisms for preventing re-hospitalization.

The facility's discharge information and instruction narrative furnishes the community provider with a thorough evaluation of the consumer's status at the time of discharge including information regarding medication management, involvement in psychosocial programming while hospitalized, current financial status, and the level of involvement with the family and/or LAR. PGH often utilizes trial visits with on-going contact by the facility social worker to help the consumer adjust to his/her new environment. Follow-up activities can last as long as 90 days post discharge depending on the consumer's family availability and level of functioning.

Environment of Care

1. The physical environment is suitable to meet the individualized residential and treatment needs of the patients and is well maintained.

Tours were conducted on all of the residential units within the hospital. Overall the facility was clean and well maintained. However, there was a noticeable odor on 1 West and 2 West. A bathroom on 3 East in the programming area was odor free but the toilets were not clean.

Efforts to make this institutional setting appear more homelike were noted. Each floor in the four-story building has east and west wings. The west wing on each floor serves as the residential area. The east wing is used to provide day programming for persons residing in the adjoining residential area. The long hallways, which have markers so consumers can measure the distance they are walking, have a nursing station in the middle allowing staff to perform some duties while remaining centrally located. Each unit has one or more common rooms. Typically each common room has cushioned furniture, a TV, plants, lots of windows, an orientation board with the date, day, weather, and the season. The rooms are located on one side of the hallway with 3-4 beds in each room. Large windows allow much natural light in the residential and day programming areas. The windows were covered with blinds, curtains or valences, allowing for adequate privacy. The bedrooms were modestly decorated by the facility. Consumers are encouraged to bring personal effects such as pictures, quilts, stuffed animals, and dolls. Each unit has a dining area dedicated to the unit consumers.

OIG observed lunch on the first day of the inspection. The dining room was attractively decorated. The food that was served for lunch was a standard meal for all with some variations depending on the dietary needs of individual consumers. The facility uses the cook/chill method for food preparation and handling. Eight consumers were interviewed regarding the quality and quantity of the food. All indicated that the food tasted good, but 3 of the consumers from Unit 1 reported that their food is usually cold by the time it is served. All reported that they were satisfied with the portions of food served. Two of the consumers indicated they would like to have greater variety in drink selections.

The installation of a fire alarm system in Building 15 is currently underway. The cost of the project is $731,000. Two additional capital improvement projects have been approved and funded but are currently in the design phase. These include the replacement of freight and pressure elevators and replacement of the emergency generator, both in Building 15. The combined cost of these projects is $1,000,000.

Administrative staff reported that the three most critical capital improvement projects that need to be addressed include:

- Replacement of the PGH steam line
- Demolition of abandoned buildings
- Construction of an addition to Building 15 for programming space

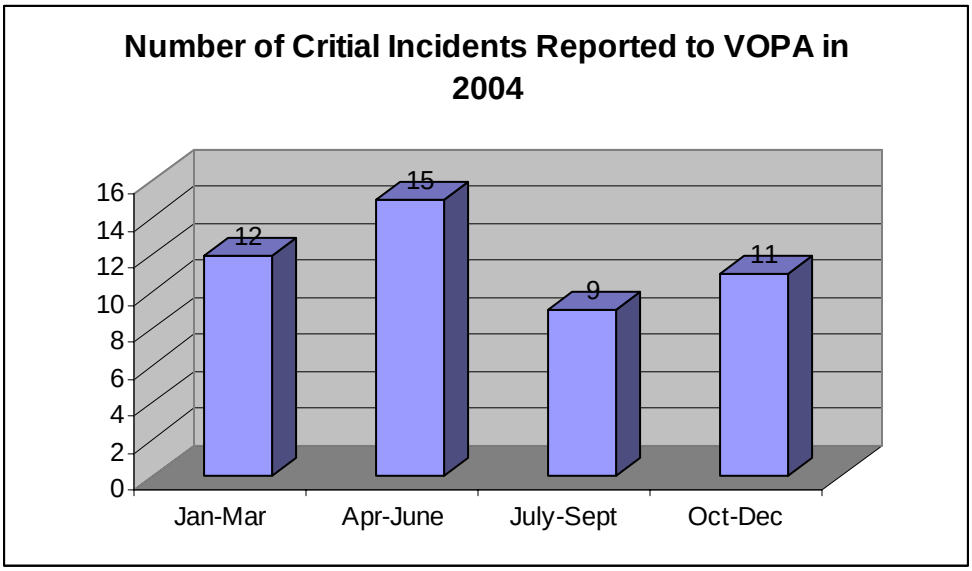
2. There are systems in place to assure that the environment of care is safe and that consumers are protected.

Administrative staff interviewed maintained that the safety of the consumers and staff is the foremost concern of this facility. It was reported that safety is promoted through environmental checks, on-going inspections, staff training, and the monitoring of serious incidents, complaints and allegations of abuse and neglect.

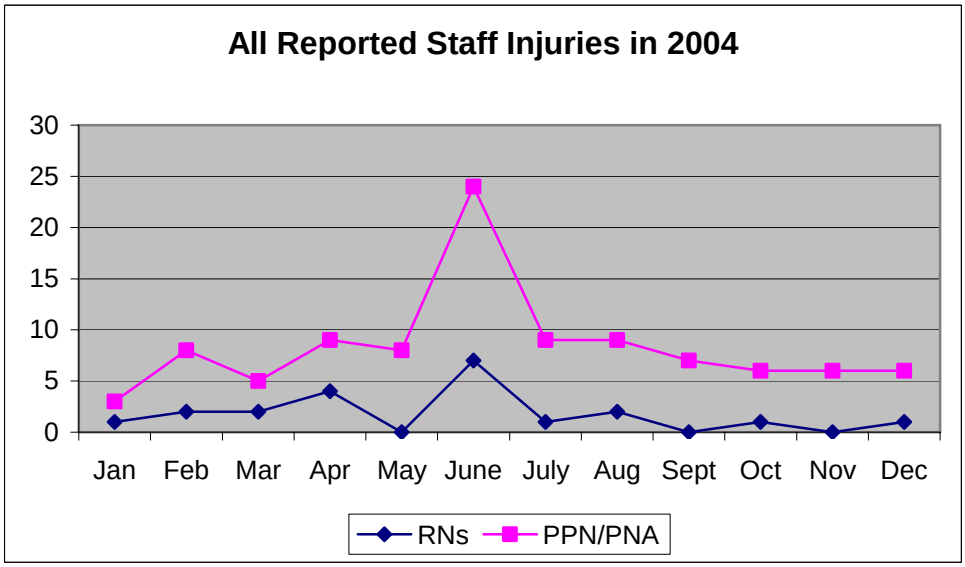
Building maintenance and safety checks are the joint responsibility of Buildings and Grounds and Campus Security. Routine rounds of all the buildings are made to assure that all equipment is in good working order and potentially hazardous situations are dealt with before a problem develops. Staff is expected to report any areas that need repair or present a risk as soon as noted. Work orders are created and completed based on the levels of risk involved, with potential life, health and safety code violations attended to immediately.

Staff is trained in key areas that have a direct impact on consumer safety such as fire safety procedures, managing challenging and difficult consumers, medication risks and benefits, human rights and the reporting of allegations of abuse and neglect. The facility has a risk management program that identifies, evaluates and seeks to reduce the risks associated with injuries, property loss and other areas of liability. Data is tracked for trends regarding a number of key indicators such as patient injuries, patient related staff injuries, allegations of abuse and neglect, formal and informal complaints and incidents of seclusion and restraint.

According to the information provided by the facility, there were 54 critical incidents at the facility in 2004. Of these, 47 met the criteria for reporting to the Virginia Office for Protection and Advocacy (VOPA). The following graph shows the number of VOPA reportable incidents per quarter for 2004.

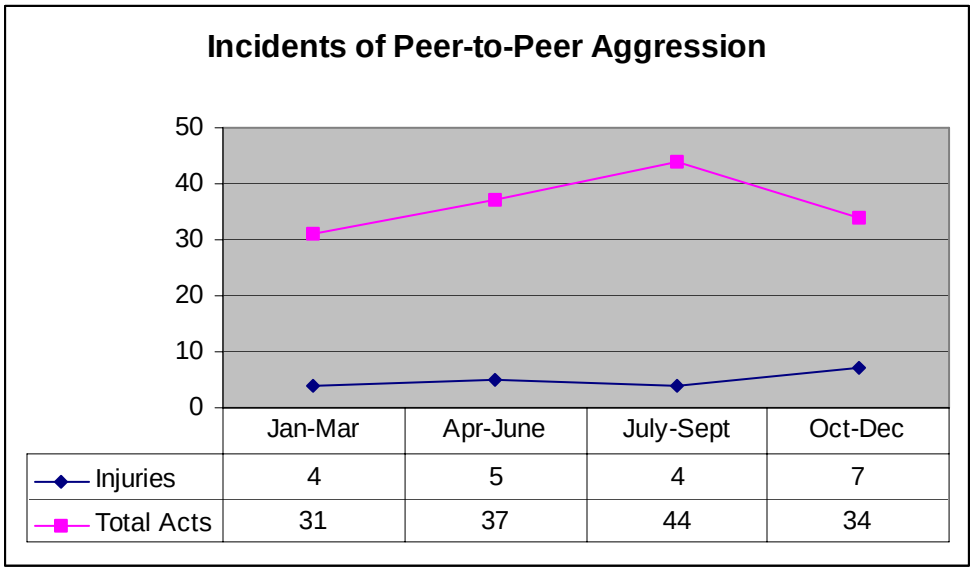


Information provided by the facility indicated that there were 127 reported staff injuries during 2004, of which 84 occurred as a result of an aggressive act by a consumer. The following graph shows the number of incidents of staff injuries as reported by the facility during 2004 for RNs and PPNs/PNAs.



Staff members having the most "hands-on" contact with the consumers sustained the highest number of injuries. The facility reported that the spike in injuries that occurred both for the RNs and PPN/PNAs was due to the behavioral difficulties experienced by two consumers during that month.

According to the data provided by the facility, there were 146 incidents of peer-to-peer aggression during 2004. Of these incidents, 20 resulted in injuries to one or both of the consumers involved. The following graph shows the total number of incidents and those resulting in injury for each quarter of 2004.



	Jan-Mar	Apr-June	July-Sept	Oct-Dec
Injuries	4	5	4	7
Total Acts	31	37	44	34

Interviews with nursing staff confirmed that the incidents of aggression within the facility resulted in a limited number of injuries for the consumers. It was reported that the majority of incidents involved the aggressor shoving or striking out at the closest person instead of the aggression being aimed at a particular person. The staff has been reviewing the cases in an effort to minimize reoccurrence.

All staff are provided training regarding human rights and the reporting of abuse and neglect. There were 9 allegations of abuse and neglect reported in 2004, of which 1 was substantiated. Consumers and/or their LARs filed 76 formal complaints and 26 informal complaints during 2004. This facility did not have any incidents that required the use of seclusion, physical holds or mechanical restraints during 2004.

All 11 of the staff and 3 of the 4 consumers interviewed reported feeling safe within this setting. Staff identified the following mechanisms within the facility to assure that consumers are protected and safe:

- Environmental engineering techniques, such as maintaining small groups, good lighting and cleaning up spills immediately
- Providing adequate staffing
- Good communication regarding consumer care in team meetings

- Risk assessment and prevention activities
- Regular status checks of the consumers
- Facility inspections and drills

Quality and Accountability

1. There are systems in place to assure that the services provided from the time of admission to discharge are quality services.

PGH has a quality management program. The program is intended to assure that the processes that govern quality within the setting are designed to effectively monitor, analyze and improve patient outcomes.

Interviews revealed that the leadership team believes that a central function of the quality management committee is to "conduct ongoing evaluation of the services provided and make the necessary improvements so that the services received by the consumers maximize each person's recovery".

Both the quality management team and the risk management team work cooperatively to assure that the services provided are safe and effective. The facility monitors over 30 quality indicators. Among the indicators monitored are: incidents of aggression, adverse drug reactions, deaths, medication use, the use of protective devices, staff turnover and overtime, staff and consumer injuries, consumer and family complaints.

2. The facility has an accurate understanding of all of the stakeholders' perceptions regarding the services provided by the facility.

Interviews with staff on all levels pointed out that quality performance improvement initiatives are based on obtaining accurate and current feedback from all stakeholders. Staff reported that any interaction with the consumers, families, and community providers presents an opportunity for obtaining and providing information regarding the course of treatment for each consumer.

Social workers are the primary contact with the families and community liaisons. Open communication regarding what is working and what needs improvement for the consumer is encouraged. Feedback regarding service provision as it is linked to discharge planning is obtained during weekly contacts.

In addition, the facility conducts patient/caregiver satisfaction surveys. Meetings are held with referring CSBs to obtain information regarding ways to improve the working relationship between the two organizations in order to improve patient care. The facility leadership described a good working relationship with members of the Central Office, particularly those in the Office of Mental Health Services.

Recommendations:

The OIG has the following recommendation regarding the Piedmont Geriatric Hospital as a result of this inspection. Based on the inspections of all 9 mental health hospitals and mental health institutes, a systemic review report will be issued in the near future that includes additional recommendations for all mental health facilities.

Finding #1: Observations revealed that psychosocial rehabilitation programming (PSR) was not occurring as scheduled with a number of cancellations. Consumer engagement and participation in the PSR sessions was very limited and in some groups was not occurring.

> **Recommendation:** It is recommended that the facility develop a workgroup that involves consumers, clinical staff and direct care staff to review active treatment programming in the facility and develop strategies for improving the effectiveness of the PSR program. A mechanism should be developed to monitor consistency between the planned program and the services that are actually delivered.
>
> *DMHMRSAS Response: The Department will be monitoring the plan of correction for increasing the active treatment participation of the consumers at PGH which includes the following:*
>
> - *Rehabilitation Staff of the facility will assume overall responsibility for the psychosocial program scheduling and program activities on each Unit by June 1, 2005.*
> - *Rehabilitation Staff will continue to train direct care and nursing staff on appropriate group and individual activities.*
> - *Direct care/nursing staff will continue to implement psychosocial group activities, which will be developed by clinical staff.*
> - *The Clinical Leadership Team will develop a monitoring system by June 1, 2005 to ensure that the unit program teams meet on a monthly basis to review or modify program concerns.*
> - *The Clinical Leadership team will ensure, through a quarterly monitoring process, that there is consistency between planned scheduled programs and the actual service delivery. The Rehabilitation Director, Recreation Supervisor, and Clinical Nurse Specialists will review posted program schedules with rehab staff monthly, and monitor programs on a monthly basis to ensure that mandated standards are consistently met.*